Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Immune Globulin Intravenous (IGIV) Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

IGIV requires prior authorization. Additional information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/druglist**.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m
Member's place of residence	☐ home ☐ nursing facility		Height	Weight	

Medication information

Drug name requested	Dose, frequency, and duration	Drug NDC (if known) or service code
Provide rate of administration. **Note:** Rate of administration may require adjustment for members with or at risk for renal dysfunction.		

Indication for IGIV (Check one or all that apply.):

☐ Immunodeficiency syndrome
Provide date and result of most recent serum immunoglobulin levels.

☐ Idiopathic thrombocytopenic purpura (ITP)
Provide date and result of most recent platelet count.
Is member actively bleeding? ☐ Yes. (Describe) ☐ No

☐ B-cell chronic lymphocytic leukemia (CLL)

☐ Kawasaki disease
Provide date of onset.

☐ Bone marrow transplantation
Provide type and date of transplant.

☐ Pediatric HIV infection
Provide date and result of most recent CD4 count.

☐ Other (describe):

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*	
Address		City	State	Zip *Optional*

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date